

Emotional Disorders in Children

Nikolaos Georgoulas

*South-West University “Neofit Rilski”, BULGARIA
Faculty of Philosophy, Blagoevgrad*

Received 18 November 2019 ▪ Revised 27 December 2019 ▪ Accepted 28 December 2019

Abstract

The child and adolescent psychopathology have been categorized into two broad classes, emotional (also called internalizing) and behavioral (externalizing) problems (disorders). In this paper, we describe the emotional disorders in children. Emotional disorders signify a core disturbance in introjective emotions and mood, namely, sorrow, guilt, fear and worry. These emotional disorders; anxiety disorders, depressive disorders, obsessive-compulsive and related disorders, trauma and stressor-related disorders in childhood and adolescence period will be discussed in more detail.

Keywords: emotional disorders, anxiety disorders, depressive disorders, obsessive-compulsive disorders, trauma and stressor-related disorders.

1. Introduction

Emotional (internalizing) disorders are characterized by the following key behaviors: depression, withdrawal, anxiety, and loneliness (Smith, 2018). Additional behavioral features of internalizing disorders are poor self-esteem, suicidal behaviors, bad academic progress, and social withdrawal (Smith, 2018). Internalizing these additional one's problems, like sadness, can cause the problems to grow into larger burdens such as social withdrawal, suicidal behaviors or thoughts, and other unexplained physical symptoms (DiMaria, 2014).

According to DSM-5 (APA, 2013), emotional disorders in childhood and adolescence, which are characterized with high levels of negative affectivity, include:

- Anxiety disorders,
- Depressive disorders,
- Obsessive-compulsive and related disorders,
- Trauma and stressor-related disorders (Smith, 2018).

2. Anxiety disorders

The diagnosis and classification of anxiety disorders in children and adolescents is relatively new (Zahn-Waxler, Klimes-Dougan & Slattery, 2000).

Similar to all other mental disorders, the *anxiety disorders* are described and classified in the DSM and the ICD.

© **Authors.** Terms and conditions of Creative Commons Attribution 4.0 International (CC BY 4.0) apply.

Correspondence: Nikolaos Georgoulas (PhD student), South-West University “Neofit Rilski”, Faculty of Philosophy, Blagoevgrad, BULGARIA. E-mail: nikosgeorg@windowlive.com.

As Beesdo and co-authors (2009) note out, although across these two systems many anxiety disorders share common clinical characteristics (for example, extensive anxiety, physiological anxiety symptoms, behavioral disturbances such as extreme avoidance of feared objects, and associated distress or impairment), all they differ in a substantial degree.

For the first time anxiety disorders have been classified in two separate diagnoses in the classification of mental disorders offered by DSM-II: withdrawing reaction and overanxious reaction (APA, 1968).

In the next revision of the DSM – DSM-III (APA, 1980) a separate diagnostic section “anxiety disorders of childhood and adolescence” have been added, which contained the following types of Anxiety disorders: separation anxiety disorder, overanxious disorder, and avoidant disorder of childhood or adolescence.

The DSM-IV, published in 1994, made the following changes in classification of anxiety disorders: separation anxiety disorder was considered as the only anxiety disorder that is unique to childhood; overanxious disorder was subsumed under generalized anxiety disorder and avoidant disorder – under social phobia (APA, 1994). Also, there were several other disorders in this revision of DSM that have implications to both adults and children, namely: panic disorder, agoraphobia, specific phobia, social phobia, obsessive-compulsive disorder, generalized anxiety disorder, and post-traumatic stress disorder.

In the latest revision of *Diagnostic and Statistical Manual of Mental Disorders* – DSM-5, no anxiety disorders is considered as unique to childhood. All types of anxiety disorders have implications to children, adolescents and adults. Also, diagnostic criteria for most of the anxiety disorders have undergone several changes from DSM-IV to DSM-5 (APA, 2013). According to the DSM-5 classification, anxiety disorders include separation anxiety disorder, selective mutism, specific phobias, social anxiety disorder, panic disorder, with agoraphobia, generalized anxiety disorder (APA, 2013).

Indeed, anxiety and fear are normal and often and adaptive emotions in the development of each child, but they (anxiety and fear) meet the criteria for a clinical anxiety disorder when the concerns are persistent and excessive, causing notable distress or impairment in day-to-day life (DSM-5, APA, 2013).

Common manifestations of anxiety disorders include a set of physical symptoms such as increased heart rate, shortness of breath, sweating, trembling, shaking, chest pain, abdominal discomfort and nausea, and many other symptoms such as worries about things before they happen, constant concerns about family, school, friends, or activities, repetitive, unwanted thoughts (obsessions) or actions (compulsions), fears of embarrassment or making mistakes, low self-esteem, lack of self-confidence and other (Ogundele, 2018).

Epidemiological studies show that anxiety disorders are the most frequent mental disorders in childhood and adolescence and for this reason appear to be the earliest of all forms of psychopathology (Smith, 2018; Zahn-Waxler, Klimes-Dougan & Slattery, 2000). Furthermore, anxiety disorders demonstrate the tendency to become chronic and always are related to considerable developmental, psychosocial, and psychopathological complications (Beesdo et al., 2009).

Age-related appearance of the different types of anxiety disorders in children has been well evidenced. Zahn-Waxler, Klimes-Dougan and Slattery (2000) provide a brief summary of the data on the typical onset of each type of anxiety disorders. Separation anxiety disorder, which refers to a very strong fear of separation from primary caretakers, most frequently emerges during early and middle childhood. Specific phobias, which refer to a freezing fear of concrete objects or situations, can emerge in children of all ages, as elevated rates of animal phobias can be seen in young children and social-related phobias become more common in middle childhood and

adolescence. Generalized anxiety disorder which is reflected in pervasively excessive worry is basically for typical older children and adolescents. Panic disorder has a higher incidence among adolescents than among children and often its appearance is related with puberty (Killen, Hayward, Hammer, Litt & Wilson, 1992).

Regarding etiology of anxiety disorders, many variables such as demographic, neurobiological, family-genetic, personality, or environmental factors, are considered to be risk factors for their emergence. According to studies' findings among the most prominent risk factors, are parental psychopathology, behaviorally inhibited temperament, or early life adversity (for a literature review see Beesdo et al., 2009).

3. Depressive disorders

The three most common mood disorders are major depressive disorder, persistent depressive disorder (formerly dysthymic disorder), and disruptive mood dysregulation disorder (APA, 2013).

Major depressive disorder in childhood is characterized by a period of disturbance in mood that may include depressed affect, anhedonia, or irritability, as well as cognitive and vegetative symptoms.

Persistent depressive disorder (dysthymic disorder) in childhood is a persistent, milder but more chronically depressed mood or irritability, as cognitive and/or vegetative symptoms also may be present.

Disruptive mood dysregulation disorder is a new diagnosis added to DSM-5. This disorder belongs to the group of depressive disorders for children up to 12 years of age. The reason for including disruptive mood dysregulation disorder in depressive disorders' group is prompted by the finding that "children with this symptom pattern typically develop unipolar depressive disorders or anxiety disorders, rather than bipolar disorders, as they mature into adolescence and adulthood (APA, 2013: 155).

Disruptive mood dysregulation disorders a childhood disorder characterized by a pervasively irritable or angry mood. The symptoms include frequent episodes of severe temper tantrums or aggression (more than three episodes a week) in combination with persistently negative mood between episodes, lasting for more than 1 year in multiple settings, beginning after 6 years of age but before the child is 10 years old (Grau et al., 2018; Ogundele, 2018).

According to the epidemiological data, less than 1% of children in preschool age, about 2% of school-aged children, and between 2% and 8% of adolescents suffer from major depressive disorder (Kashani & Orvaschal, 1988).

Regarding persistent depressive disorder, less than 2% of children and up to 8% of adolescents meet the diagnosis criteria (Lewinsohn, Hops, Roberts, Seeley & Andrews, 1993).

The prevalence of disruptive mood dysregulation disorder in primary school age is less than 1% (Grau et al., 2018).

Clinical observations have shown that depressive disorders often occur in children under stress, who experience some kind of loss, or in children who have attentional, learning, conduct or anxiety disorders and other chronic diseases or defects (Ogundele, 2018). Also, there is evidence for the tendency to run in families (Lu et al., 2012). The typical symptoms of depression are low mood, frequent sadness, tearfulness, crying, decreased interest or pleasure in almost all activities, or inability to enjoy previously favorite activities, hopelessness, persistent boredom, low energy, social isolation, poor communication, low self-esteem and guilt, feelings of worthlessness, extreme sensitivity to rejection or failure, increased irritability, agitation, anger, or hostility,

difficulty with relationships, frequent complaints of physical illnesses such as headaches and stomach aches, frequent absences from school or poor performance in school, poor concentration, a major change in eating and/or sleeping patterns, weight loss or gain when not dieting, talk of or efforts to run away from home, thoughts or expressions of suicide or self-destructive behavior (DSM-5, APA, 2013).

Anxiety and depressive disorders are in high comorbidity. Anxiety disorders in childhood and adolescence often precede and predict later depressive disorders as evidenced several longitudinal studies (Cole et al., 1998; Lewinsohn, Gotlib & Seeley, 1995).

4. Obsessive-compulsive disorders

The group of obsessive-compulsive and related disorders includes the following disorders: obsessive-compulsive disorder (OCD), body dysmorphic disorder, hoarding disorder, trichotillomania (hair-pulling disorder), excoriation (skin-picking) disorder, and other. “The obsessive-compulsive and related disorders differ from developmentally normative preoccupations and rituals by being excessive or persisting beyond developmentally appropriate periods. The distinction between the presence of subclinical symptoms and a clinical disorder requires assessment of a number of factors, including the individual's level of distress and impairment in functioning.” (DSM-5, APA, 2013: 235).

It is important to note that historically obsessive-compulsive disorder has been considered to be an anxiety disorder, but due to the accumulation of evidence for essential differences in the phenomenology and etiology of obsessive-compulsive disorder compared with other anxiety disorders, its classification has changed within DSM-5 and it now belongs to the new section encompassing a number of other disorders with two common underlying symptoms, namely repetitive thinking and repetitive behavior (Stein, 2010).

Obsessive-compulsive disorder in childhood and adolescence is associated with two specific sets of distressing symptoms: persistent and unwanted intrusive thoughts, images and urges (called obsessions) and time-consuming repetitive behaviors or mental acts and rituals performed in an attempt to reduce anxiety (called compulsions). Both obsessions and compulsions are unpleasant and distressing to the child (Krebs & Heyman, 2015).

Epidemiological studies have shown that the incidence of obsessive-compulsive disorder among child and adolescent population is between 0.25-4% (Heyman, Fombonne & Simmons 2001). Typically untreated symptoms tend to become chronic and cause serious problems in a subject's daily functioning. Moreover, WHO ranks obsessive-compulsive disorder as one of the most impairing disorder (in Krebs & Heyman, 2015).

Also, similar to other emotional disorders, the presence of the obsessive-compulsive disorder in childhood is associated with increased risk of other psychiatric disorders in adulthood (Krebs & Heyman, 2015).

5. Trauma and stressor-related disorders

Trauma and stressor-related disorders encompass disorders in which exposure to or experience of a traumatic or stressful event is an immanent diagnostic criterion. According to DSM-5, this group includes the following disorders: reactive attachment disorder, disinhibited social engagement disorder, posttraumatic stress disorder (PTSD), acute stress disorder, and adjustment disorders. Trauma and stressor-related disorders are closely related to anxiety disorders, obsessive-compulsive and related disorders, and dissociative disorders (APA, 2013).

Reactive attachment disorder of infancy or early childhood refers to a markedly disturbed and developmentally inappropriate attachment behaviors, in which a child rarely or minimally turns preferentially to an attachment figure for comfort, support, protection, and nurturance. The key symptom is absent or highly underdeveloped attachment between the child and his/her caregivers.

Against the background of inhibited, emotionally withdrawn behavior toward adult caregivers, these children often demonstrate episodes of unexplained irritability, sadness, or fearfulness including during nonthreatening interactions with adult caregivers.

Reactive attachment disorder often co-occurs with developmental delays, especially in domains of cognition and language, and less frequently with stereotypies and other signs of severe neglect, such as malnutrition or poor care.

The disorder is uncommon and occurs in less than 10% of young children exposed to severe neglect before being placed in foster care or raised in institutions.

Disinhibited social engagement disorder refers to a behavior that involves inappropriate for a given culture, overly familiar behavior with relative strangers. This overly familiar behavior violates the social boundaries of the culture. A diagnosis can be made after 9 months of age, i.e., before a child is developmentally able to form selective attachments. The disorder is rare and occurs mainly in children, who have been severely neglected and subsequently placed in foster care or raised in institutions.

Disinhibited social engagement disorder has been described from the second year of life through adolescence. There are no published data for its manifestation in adulthood.

Symptoms vary for different ages. For example, the youngest children with the disorder show reticence when interacting with strangers; reticence to approach, engage with are not observed in young children; in preschoolers, verbal and social intrusiveness dominate, often in combination with attention-seeking behavior; during the period of middle childhood verbal and physical over familiarity continue to dominate accompanied by inauthentic expressions of emotion; adolescents demonstrate indiscriminate behavior to all, including to their peers, as well as prominent tendency to have more “superficial” peer relationships and more peer conflicts. Serious social neglect is the only known risk factor for the disinhibited social engagement disorder.

Posttraumatic stress disorder is characterized by a set of typical symptoms following experience of one or more traumatic events. These symptoms can be emotional reactions to the traumatic event, such as fear, helplessness, horror), fear-based re-experiencing of the traumatic event, anhedonic or dysphoric mood states and negative cognitions. In some individuals, arousal and reactive-externalizing symptoms are prominent, in others – dissociative symptoms, and in some individuals a combination of these symptom pattern is observed.

Children with posttraumatic stress disorder often demonstrate a heightened sensitivity to potential threats, including both those that are related to the traumatic experience (for example, being fearful of dogs after a dog attack) and those that are not related to the traumatic event (for example, being fearful of a seizure) (McLaughlin et al., 2013).

People who suffer from this disorder are easily frightened at unexpected stimuli, for example, loud noises or unexpected movements. They have difficulties to concentrate and remember even daily events, and children have trouble focusing at school. Typical for them are the problems with sleep onset and maintenance, often related to experience of nightmares or flashbacks about the trauma. Some persons, who suffer from posttraumatic stress disorder (typical of adults) may also experience persistent dissociative symptoms of detachment from their bodies (depersonalization) or the world around them (derealization) (APA, 2013).

Children with posttraumatic stress disorder often play in a way that repeats or recalls the trauma. They act impulsively or aggressively and feel nervous or anxious frequently. In young children loss of language also could be observed (McLaughlin et al., 2013).

Traumatic events can be very different, but most often include physical violence, an accident, a natural disaster, war, or sexual abuse. Children may experience traumatic events themselves, or may just be observers of these events (McLaughlin et al., 2013).

The prevalence of posttraumatic stress disorder may vary across development. In Europe, projected lifetime risk for posttraumatic stress disorder has been estimated around 0.5-1.0%, with a lower incidence in the child population (from preschool age to adolescence) (APA, 2013; Perkonig et al., 2000).

Posttraumatic stress disorder in children frequently has been presented with psychiatric comorbidity, including internalizing and externalizing behavior problems, substance use disorders among adolescents, self-harm and suicidal behaviors (McLaughlin et al., 2013; Lewis, 2019)

6. Conclusions

Unfortunately, in the last 1-2 decades, a tendency of significant increases in the prevalence of childhood social, emotional, and behavioral problems have been observed (Layard & Dunn, 2009). Emotional and behavioral disorders in childhood have significant negative impacts not only on the individual, but also on his/her family and the society as a whole. Their effect on the individual can be seen in the form of poor academic, occupational and psychosocial functioning. Their effect on the family can be seen in the form of trauma, disruption, psychological problems and all possible consequences and damages of deviant and delinquent behaviors of the affected family member. And finally, their effect on the society can be seen in the form of direct behavioral consequences related to the problems caused to the victims of crime or aggression in homes, schools and communities, as well as financial costs of services to treat the affected individuals (Ogundele, 2018).

Acknowledgements

This research did not receive any specific grant from funding agencies in the public commercial, or not-for-profit sectors.

The author declares no competing interests.

References

- APA (1968). *Diagnostic and statistical manual of mental disorders* (Second edition). Washington, DC: American Psychiatric Press.
- APA (1980). *Diagnostic and statistical manual of mental disorders* (Third edition). Washington, DC: American Psychiatric Press.
- APA (2000). *Diagnostic and statistical manual of mental disorders* (Fourth edition). Washington, DC: American Psychiatric Press.
- APA (2013). *Diagnostic and statistical manual of mental disorders* (Fifth edition). Washington, DC: American Psychiatric Press.

- Beesdo, K., Knappe, S., & Pine, D. S. (2009). Anxiety and anxiety disorders in children and adolescents: Developmental issues and implications for DSM-V. *Psychiatr Clin North Am.*, 32(3), 483-524.
- Cole, D. A., Peeke, L. G., Martin, J. M., Truglio, R. & Seroczynski, A. D. (1998). A longitudinal look at the relation between depression and anxiety in children and adolescents. *Journal of Consulting and Clinical Psychology*, 66(3), 451-460.
- DiMaria, L. (2014). *Internalizing behaviors and depression*. Retrieved 17 March 2018, from <http://about.com>.
- Grau, K., Plener, P. L., Hohmann, S., Fegert, J. M., Brähler, E., & Straub, J. (2018). Prevalence rate and course of symptoms of Disruptive Mood Dysregulation Disorder (DMDD): A population based study. *Zeitschrift für Kinder- und Jugendpsychiatrie und Psychotherapie*, 46(1), 29-38.
- Heyman, I., Fombonne E., Simmons H., et al. (2001). Prevalence of obsessive-compulsive disorder in the British nationwide survey of child mental health. *Br J Psychiatry*, 179, 324-9.
- Kashani, J. H., Holcomb, W. R., & Orvaschel, H. (1986). Depression and depressive symptoms in preschool children from the general population. *Am J Psychiatry*, 143(9), 1138-1143.
- Killen, J. D., Hayward, C., Litt, I., Hammer, L. D., Wilson, D. M., Miner, B., Taylor, C. B., Varady, A., & Shisslak, C. (1992). Is puberty a risk factor for eating disorders? *Am J Dis Child.*, 146(3), 323-325.
- Krebs, G., & Heyman, I. (2015). Obsessive-compulsive disorder in children and adolescents. *Arch Dis Child.*, 100(5), 495-499.
- Layard R., & Dunn, J. (2009). *A good childhood: Searching for values in a competitive age*. London: Penguin Books Ltd.
- Lewinsohn, P.M., Hops, H., Roberts, R.E., Seeley, J. R., & Andrews, J. A. (1993). Adolescent psychopathology: I. Prevalence and incidence of depression and other DSM-III-R disorders in high school students. *J Abnorm Psychol.*, 102(1), 133-44.
- Lewinsohn, P. M., Gotlib, I. H. & Seeley, J. R. (1995). Adolescent psychopathology: IV. Specificity of psychosocial risk factors for depression and substance abuse in older adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry*, 34, 1221-1229.
- Lewis, S. J., Arseneault, L., Caspi, A., Fisher, H. L., Matthews, T., Moffitt, T. E., Odgers, C. L., Stahl, D., Teng, J. Y., & Danese, A. (2019). The epidemiology of trauma and post-traumatic stress disorder in a representative cohort of young people in England and Wales. *Lancet Psychiatry*, 6(3), 247-256.
- McLaughlin, K. A., Koenen, K. C., Hill, E. D., Petukhova, M., Sampson, N. A., Zaslavsky, A. M., & Kessler, R. C. (2013). Trauma exposure and posttraumatic stress disorder in a national sample of adolescents. *J Am Acad Child Adolesc Psychiatry*, 52(8), 815-830.
- Ogundele, M. O. (2018). Behavioural and emotional disorders in childhood: A brief overview for paediatricians. *World J Clin Pediatr.*, 7(1), 9-26.
- Perkonig, A., Kessler, R. C., Storz, S., & Wittchen, H-U. (2000). Traumatic events and post-traumatic stress disorder in the community: prevalence, risk factors and comorbidity. *Acta Psychiatr Scand.*, 101(1), 46-59.
- Smith, D.D. (2018). Emotional or behavioral disorders defined. Retrieved 17 March 2018, from <https://education.com>.
- Stein, D. J., Fineberg, N. A., Bienvenu, O. J., Denys, D., Lochner, C., Nestadt, G., Leckman, J. F., Rauch, S. L., & Phillips, K. A. (2010). Should OCD be classified as an anxiety disorder in DSM-V? *Depress Anxiety*, 27(6), 495-506.
- Zahn-Waxler, C., Klimes-Dougan, B., & Slaterry, M. J. (2000). Internalizing problems of childhood and adolescence: Prospects, pitfalls, and progress in understanding the development of anxiety and depression. *Development and Psychopathology*, 12(3), 443-466.

